



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Christine Wan, M.D.

**Respondent Name**

American Zurich Insurance Company

**MFDR Tracking Number**

M4-16-3041-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 6, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

**Amount in Dispute:** \$165.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on June 14, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 3, 2015	Evaluation & Management, established patient (99213) Work Status Report (99080-73)	\$165.00	\$124.51

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
3. 28 Texas Administrative Code §129.5 sets out the guidelines for work status reports.
4. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
5. 28 Texas Administrative Code §133.210 sets out the procedures for medical documentation.
6. 28 Texas Administrative Code §134.203 sets out the fee guidelines for division-specific services.
7. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – The time limit for filing has expired.
  - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
  - 247 – A payment or denial has already been recommended for this service.

## **Issues**

1. Did the requestor forfeit the right to reimbursement for the services in dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “THE TIME LIMIT FOR FILING HAS EXPIRED.” 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Texas Labor Code §408.027(a) states that “Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.”

28 Texas Administrative Code §102.4(h) states that:

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

28 Texas Administrative Code §133.210(e) states,

It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

Review of the submitted documentation finds that the great weight of evidence supports that the requestor submitted a medical bill to the insurance carrier's agent; Sedgwick, CMS; on December 4, 2015. This date is less than 95 days from the date of service. Consequently, the division finds that the requestor has not forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

2. 28 Texas Administrative Code §134.203(c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...

- (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is \$56.20.

For procedure code 99213 on December 3, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.970000. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 0.920 is 0.929200. The malpractice (MP) RVU of 0.06 multiplied by the MP GPCI of 0.822 is 0.049320. The sum of 1.948520 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$109.51.

28 Texas Administrative Code §129.5(i) states, in relevant part:

Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15.

Therefore, the MAR for procedure code 99080-73 for date of service December 3, 2015 is \$15.00.

3. The total MAR for the disputed services is \$124.51. The insurance carrier paid \$0.00. A reimbursement of \$124.51 is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$124.51.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$124.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	<u>Laurie Garnes</u> Medical Fee Dispute Resolution Officer	<u>August 11, 2016</u> Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**